## Filing at a Glance

| | |
|---|---|
| Company: | USAble Life |
| Product Name: | Critical Illness Applications, CIP2 & CIP2-R - Rev |
| State: | Arkansas |
| TOI: | H07I Individual Health - Specified Disease - Limited Benefit |
| Sub-TOI: | H07I.001 Critical Illness |
| Filing Type: | Form |
| Date Submitted: | 11/15/2012 |
| SERFF Tr Num: | LSVX-G128772798 |
| SERFF Status: | Closed-Approved-Closed |
| State Tr Num: | |
| State Status: | Approved-Closed |
| Co Tr Num: | AR001920100004 |
| Implementation Date Requested: | 11/15/2012 |
| Author(s): | SPI Life and Specialty Ventures |
| Reviewer(s): | Rosalind Minor (primary) |
| Disposition Date: | 11/16/2012 |
| Disposition Status: | Approved-Closed |
| Implementation Date: | |

State Filing Description:

**State:** *Arkansas* **Filing Company:** *USAble Life*
**TOI/Sub-TOI:** *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
**Product Name:** *Critical Illness Applications, CIP2 & CIP2-R - Rev*
**Project Name/Number:** *Critical Illness Applications, CIP, CIP2 & CIP2-R/AR001920100004*

## General Information

Project Name: Critical Illness Applications, CIP, CIP2 & CIP2-R
Project Number: AR001920100004
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Deemer Date:
Submitted By: SPI Life and Specialty Ventures

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual, Non Employer Group - Individual
Filing Status Changed: 11/16/2012
State Status Changed: 11/16/2012
Created By: SPI Life and Specialty Ventures
Corresponding Filing Tracking Number:

Filing Description:

We are filing for your review and approval revised critical illness applications. They have been revised pursuant to the MIB requirement to change the MIB authorization to comply with final HIPAA Regulations.
These applications will replace the previously approved CIP2-APP (2-10) and CIP2-RAPP (11-10) applications which were approved on 2/12/2010 under SERFF Filing ID LSVX-126493991 (AR Filing ID 44804) and 8/2/2011 under SERFF Filing ID LSVX-G127327567 (AR Filing ID 49376), respectively.

CIP2-APP (1-13) can be used with our Critical Illness Policies, CIP2 (7-07) and CIP2-WC (7-07), which were approved on 6/29/2007 under SERFF Filing ID LSVX-125218904 (AR Filing ID 36259).

CIP2-RAPP (1-13) can be used with our Critical Illness Policies, CIP2-R (7-07) and CIP2-WC-R (7-07), which were approved on 8/2/2011 under SERFF Filing ID LSVX-G127327567 (AR Filing ID 49376).

We made the following revision to the applications: In the authorization section, added the phrase "(c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB."

The following form was previously approved by your department and will be also be used with these forms:

APP-NOTICE (9-08) - Application Notice - 10/23/2008

The application may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document, but we assure that its content will not change and its readability compliance will not be affected.

## Company and Contact

### Filing Contact Information

Rob Wittenburg, Compliance Supervisor
PO Box 1650
Little Rock, AR 72203-1650
rwittenburg@usablelife.com
501-212-8877 [Phone] 8877 [Ext]
501-235-8484 [FAX]

***State:*** *Arkansas* ***Filing Company:*** *USAble Life*
***TOI/Sub-TOI:*** *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
***Product Name:*** *Critical Illness Applications, CIP2 & CIP2-R - Rev*
***Project Name/Number:*** *Critical Illness Applications, CIP, CIP2 & CIP2-R/AR001920100004*

### Filing Company Information

USAble Life
PO Box 1650
Little Rock, AR 72203-1650
(501) 375-7200 ext. [Phone]

CoCode: 94358
Group Code: 876
Group Name: Life and Speciality Ventures (LSV)
FEIN Number: 71-0505232

State of Domicile: Arkansas
Company Type: Life & Healh
State ID Number:

## Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? No
Fee Explanation:
Per Company: No

| Company | Amount | Date Processed | Transaction # |
|---|---|---|---|
| USAble Life | $50.00 | 11/15/2012 | 64943584 |
| USAble Life | $50.00 | 11/16/2012 | 64962373 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *LSVX-G128772798* | ***State Tracking #:*** | | ***Company Tracking #:*** | *AR001920100004* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *USAble Life* |
| ***TOI/Sub-TOI:*** | *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness* | | |
| ***Product Name:*** | *Critical Illness Applications, CIP2 & CIP2-R - Rev* | | |
| ***Project Name/Number:*** | *Critical Illness Applications, CIP, CIP2 & CIP2-R/AR001920100004* | | |

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 11/16/2012 | 11/16/2012 |

## Objection Letters and Response Letters

### Objection Letters

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Pending Industry Response | Rosalind Minor | 11/16/2012 | 11/16/2012 |

### Response Letters

| Responded By | Created On | Date Submitted |
|---|---|---|
| SPI Life and Specialty Ventures | 11/16/2012 | 11/16/2012 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *LSVX-G128772798* | ***State Tracking #:*** | | ***Company Tracking #:*** | *AR001920100004* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *USAble Life* |
| ***TOI/Sub-TOI:*** | *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness* | | |
| ***Product Name:*** | *Critical Illness Applications, CIP2 & CIP2-R - Rev* | | |
| ***Project Name/Number:*** | *Critical Illness Applications, CIP, CIP2 & CIP2-R/AR001920100004* | | |

## Disposition

Disposition Date: 11/16/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | Yes |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Statement of Variability | Approved-Closed | Yes |
| **Form** | Critical Illness Application | Approved-Closed | Yes |
| **Form** | Critical Illness Application | Approved-Closed | Yes |

**State:** *Arkansas* **Filing Company:** *USAble Life*
**TOI/Sub-TOI:** *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
**Product Name:** *Critical Illness Applications, CIP2 & CIP2-R - Rev*
**Project Name/Number:** *Critical Illness Applications, CIP, CIP2 & CIP2-R/AR001920100004*

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 11/16/2012 |
| Submitted Date | 11/16/2012 |
| Respond By Date | |

*Dear Rob Wittenburg,*

***Introduction:***

*This will acknowledge receipt of the captioned filing.*

***Objection 1***

*- Critical Illness Application, CIP2-APP (1-13) (Form)*
*- Critical Illness Application, CIP2-RAPP (1-13) (Form)*
*Comments:*

*Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.*

*The fee for this submission is $50.00 per form for a total of $100.00. Please submit an additional $50.00 for this submission.*

*We will begin our review of this submission upon receipt of the additional filing fee.*

***Conclusion:***

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,*
*Rosalind Minor*

**State:** Arkansas **Filing Company:** USAble Life
**TOI/Sub-TOI:** H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
**Product Name:** Critical Illness Applications, CIP2 & CIP2-R - Rev
**Project Name/Number:** Critical Illness Applications, CIP, CIP2 & CIP2-R/AR001920100004

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 11/16/2012 |
| Submitted Date | 11/16/2012 |

*Dear Rosalind Minor,*

***Introduction:***

*The following is in response to your November 16, 2012 objection letter:*

***Response 1***

***Comments:***

*We have submitted an additional $50.00 as requested. We apologize for the error.*

***Related Objection 1***

*Applies To:*

- *Critical Illness Application, CIP2-APP (1-13) (Form)*
- *Critical Illness Application, CIP2-RAPP (1-13) (Form)*

*Comments:*

*Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.*

*The fee for this submission is $50.00 per form for a total of $100.00. Please submit an additional $50.00 for this submission.*

*We will begin our review of this submission upon receipt of the additional filing fee.*

***Changed Items:***

*No Supporting Documents changed.*

*No Form Schedule items changed.*

*No Rate/Rule Schedule items changed.*

***Conclusion:***

*We hope that with this additional information, this filing may now be considered for final approval. If you have any questions or comments, please call me at (800) 648-0271 ext. 8877. Thank you for your assistance.*

*Sincerely,*

*Rob Wittenburg*

*Sincerely,*

*SPI Life and Specialty Ventures*

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *LSVX-G128772798* | ***State Tracking #:*** | | ***Company Tracking #:*** | *AR001920100004* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *USAble Life* |
| ***TOI/Sub-TOI:*** | *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness* | | |
| ***Product Name:*** | *Critical Illness Applications, CIP2 & CIP2-R - Rev* | | |
| ***Project Name/Number:*** | *Critical Illness Applications, CIP, CIP2 & CIP2-R/AR001920100004* | | |

# Form Schedule

**Lead Form Number: CIP2-APP (1-13)**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Approved-Closed 11/16/2012 | Critical Illness Application | CIP2-APP (1-13) | AEF | Revised | Previous Filing Number: | 44804 | 44.900 | CIP2-APP (1-13).PDF |
| | | | | | | Replaced Form Number: | CIP2-APP (2-10) | | |
| 2 | Approved-Closed 11/16/2012 | Critical Illness Application | CIP2-RAPP (1-13) | AEF | Revised | Previous Filing Number: | 49376 | 44.900 | CIP2-RAPP (1-13).PDF |
| | | | | | | Replaced Form Number: | CIP2-RAPP (11-10) | | |

**Form Type Legend:**

| | | | |
|---|---|---|---|
| **ADV** | Advertising | **AEF** | Application/Enrollment Form |
| **CER** | Certificate | **CERA** | Certificate Amendment, Insert Page, Endorsement or Rider |
| **DDP** | Data/Declaration Pages | **FND** | Funding Agreement (Annuity, Individual and Group) |
| **MTX** | Matrix | **NOC** | Notice of Coverage |
| **OTH** | Other | **OUT** | Outline of Coverage |
| **PJK** | Policy Jacket | **POL** | Policy/Contract/Fraternal Certificate |
| **POLA** | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | **SCH** | Schedule Pages |

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

# CRITICAL ILLNESS APPLICATION

| Office Use Only | |
|---|---|
| Effective Date | |
| Policy Number | |
| Group Number | |
| Dept./Loc | |

☐ New Application ☐ Change Form ☐ Replaces Policy No. _____

## SECTION 1 - APPLICANT INFORMATION

| Name (First, MI, Last) | | | | Social Security No. | |
|---|---|---|---|---|---|
| Home Address | City | State | Zip | County | |
| Occupation (Be Exact) | Date of Birth | Age | Birth State or Country | Sex ☐ Male ☐ Female | Height (ft-in.) / Weight (lbs.) |
| Employer | Date Employed Full-time | Work Phone ( ) | Home Phone ( ) | Have you used any tobacco products within the past 36 months? ☐ Yes ☐ No | |

## SECTION 2 – SPOUSE & CHILDREN INFORMATION

| Full Name | Occupation | Sex | Date of birth mo. | day | yr. | Birth State or Country | Ht. Ft. Ins. | Wt. lbs. |
|---|---|---|---|---|---|---|---|---|
| (spouse) | | | | | | | | |
| (child) | | | | | | | | |
| (child) | | | | | | | | |
| (child) | | | | | | | | |

Has your spouse used any tobacco products within the past 36 months? ☐ Yes ☐ No

## SECTION 3 – PLAN SELECTION ■ New Applicant ■ Application for Change

**Select Type of Policy/Optional Rider:**

☐ CRITICAL ILLNESS WITH CANCER
☐ CRITICAL ILLNESS WITHOUT CANCER
☐ OPTIONAL RECURRENT BENEFIT RIDER

**I hereby apply for the following coverage:**

☐ Applicant Only
☐ Applicant & Spouse
☐ Applicant & Children
☐ Applicant, Spouse & Children

| | Face Amount Applying For (Increments of $5,000) | Number of Units ($5,000 per Unit) | Rate | Monthly Premium |
|---|---|---|---|---|
| **Applicant** | | X | = $ | |
| **Spouse*** | | X | = $ | |
| **Children**** ☐ $5,000 ☐ $10,000 | | X | = $ | |
| | | **TOTAL PREMIUM AMOUNT** | | $ |

*** Spouse's signature required if amount exceeds $25,000.**
**** The maximum amount of Children's coverage is $10,000.**

1. Does any person applying for coverage currently have a Critical Illness or Cancer Policy with us or any other insurance company? ☐ Yes ☐ No If yes, give name of company, list type of policy and amount of coverage._____
2. REPLACEMENT: Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____
3. OUTLINE: Have you received the Outline of Coverage (in those states where required by law)? ☐ Yes ☐ No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" on page 2 of this application; (c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (f) agree that this authorization shall be valid for two (2) years from the application date; (g) know that I or my authorized representative may revoke this authorization at any time; (h) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (i) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand no person to be insured is also covered by any Title XIX program – Medicaid or any similar name (Not applicable to residents of AZ, MO, NC, OR, or SC). I understand failure to disclose a proposed insured person's true health condition may void this policy.

**Be sure to complete the Medical Information on page 2/reverse side.**



Signed at: _____ (City and State) Date of Application _____ (Month, Day, Year)

Date Received Home Office

I have truly and accurately recorded the information supplied by the applicant.

X _____ Agent's Signature

X _____ Applicant's Signature

CIP2-APP (1-13)

X _____ Spouse's Signature (if required)

**NOTIFICATION FOR THE PROPOSED INSURED— Please read carefully and detach for your records.**

**Notice of Insurance Information Practices** - In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

| Employee's Name (Last, First, M.I.) | Social Security # | Employer |
|---|---|---|
| | | |

**CRITICAL ILLNESS — MONTHLY PREMIUMS PER $5,000 UNIT**

| | CRITICAL ILLNESS WITH CANCER | | | | | CRITICAL ILLNESS WITHOUT CANCER | | | |
|---|---|---|---|---|---|---|---|---|---|
| | INCLUDES RECURRENT BENEFIT | | WITHOUT RECURRENT BENEFIT | | | INCLUDES RECURRENT BENEFIT | | WITHOUT RECURRENT BENEFIT | |
| **Issue Age** | **Non-Tobacco** | **Tobacco** | **Non-Tobacco** | **Tobacco** | **Issue Age** | **Non-Tobacco** | **Tobacco** | **Non-Tobacco** | **Tobacco** |
| All Children | $1.66 | $1.66 | $1.46 | $1.46 | All Children | $1.00 | $1.00 | $0.82 | $0.82 |
| 18 - 29 | 2.50 | 5.22 | 2.22 | 4.58 | 18 – 29 | 1.76 | 3.06 | 1.48 | 2.52 |
| 30 - 39 | 4.08 | 9.56 | 3.62 | 8.38 | 30 – 39 | 2.74 | 5.72 | 2.30 | 4.68 |
| 40 - 49 | 6.44 | 16.92 | 5.68 | 14.80 | 40 – 49 | 4.20 | 10.06 | 3.50 | 8.18 |
| 50 - 59 | 9.92 | 27.10 | 8.74 | 23.68 | 50 – 59 | 6.30 | 15.82 | 5.20 | 12.82 |
| 60 - 64 | 13.36 | 34.06 | 11.74 | 29.74 | 60 – 64 | 8.36 | 19.96 | 6.88 | 16.16 |

## SECTION 4 – BENEFICIARY

■ **Name Beneficiary** ■ **Change of Beneficiary**

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

| Name | Relationship | Date of Birth | Primary or Secondary | Indicate % Distribution |
|---|---|---|---|---|
| | | | ☐ Primary or ☐ Secondary | |
| | | | ☐ Primary or ☐ Secondary | |

## SECTION 5 – MEDICAL INFORMATION

**NOTE: If Spouse or Children coverage IS NOT being requested answer questions only as applies to applicant.**

1. Has any person to be insured ever been diagnosed with or advised to take a diagnostic test, been treated by a member of the medical profession, or taken medication for:

| | Yes | No |
|---|---|---|
| (a) Any form of internal cancer, carcinoma in-situ, malignant melanoma, or other precancerous findings? | ☐ | ☐ |
| (b) Any chronic or progressive disease or disorder of the heart, kidneys, liver, lungs, pancreas, or bone marrow? | ☐ | ☐ |
| (c) Quadriplegia, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease? | ☐ | ☐ |
| (d) Alcohol or substance abuse (in the last 5 years)? | ☐ | ☐ |
| (e) Heart Attack or heart disease, stroke or transient ischemic attack (TIA), or been advised to have coronary bypass surgery, stent insertion, or laser treatment to coronary arteries? | ☐ | ☐ |
| (f) Diabetes (except during a pregnancy), or any blood pressure reading recorded in the last three months exceeding 149/94? | ☐ | ☐ |
| (g) Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)? | ☐ | ☐ |

2. Has any person to be insured ever been diagnosed by a member of the medical profession with, or does anyone currently have:

| | Yes | No |
|---|---|---|
| (a) Any abnormal cancer screening tests currently being followed by your doctor? | ☐ | ☐ |
| (b) Any cysts, growths, lumps, or any mole or freckle that has bled, become painful, changed color, increased in size, required medical attention or evaluation for which you have not yet sought medical advice? | ☐ | ☐ |
| (c) Carotid artery stenosis, peripheral vascular disease, chronic atrial fibrillation, or chest pain not evaluated by a medical doctor and determined to be non-cardiac? | ☐ | ☐ |
| (d) Multiple sclerosis, memory loss, schizophrenia, systemic lupus erythematosus, pulmonary or cystic fibrosis? | ☐ | ☐ |

3. Has any person to be insured had any two or more natural parents, brothers, or sisters diagnosed with coronary artery disease, diabetes, or the same cancer (other than skin cancer) prior to age 55? Or, has any person to be insured had one or more natural parents, brothers, or sisters diagnosed with coronary artery disease or colorectal cancer prior to age 45? ☐ Yes ☐ No
4. Is any person to be insured currently taking any prescription medicine(s) or have they taken prescription medicine(s) in the last three (3) years? ☐ Yes ☐ No
5. Has any person to be insured had any abnormal tests (including blood test, urinalysis, X-ray, MRI, ultrasound, stress test, echocardiogram) not found to be normal or benign on further testing, or requiring follow-up by a physician? ☐ Yes ☐ No
6. Does any person to be insured have any consultation, surgery, or test scheduled or anticipated? ☐ Yes ☐ No
7. Has any person to be insured ever been diagnosed by a member of the medical profession with a benign tumor, disorder of blood or autoimmune disorder, digestive disorder, urinary system or reproduction organs disorder, heart or circulatory disorder, hypertension (list last two blood pressure readings and dates), mental or nervous disorder, neurological disorder, or respiratory disorder? ☐ Yes ☐ No
8. Has any person to be insured had any application for critical illness, disability, health, or life insurance modified, rated, or declined in the last 5 years? ☐ Yes ☐ No
9. Give details to any "Yes" answers, including name of person, prescription medicine(s), diagnosis, and dates of treatment: _____
10. Name, address, and phone number of the personal physician(s) of all applicants with date last seen, reason for visit, and results:

**IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS:** (1) The policy is delivered to the Owner; (2) The first modal premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application. I understand that my policy will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

**Insurance Fraud Warning -** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.



**Medical Information Bureau Disclosure Notice** - Information regarding your insurability will be treated as confidential. USAble Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Braintree, Massachusetts 02184-8734. USAble Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

**Federal Fair Credit Reporting Act Notice** - In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

# CRITICAL ILLNESS APPLICATION

| Office Use Only | |
|---|---|
| Effective Date | |
| Policy Number | |
| Group Number | |
| Dept./Loc | |

☐ New Application ☐ Change Form ☐ Reinstatement Policy ☐ Replaces Policy No. _____

## SECTION 1 - APPLICANT INFORMATION

| Name (First, MI, Last) | | For Name Change, Give Prior Last Name | | Social Security No. | |
|---|---|---|---|---|---|
| Home Address | | City | State | Zip | County |
| Date of Birth | Age | Birth State or Country | Gender ☐ Male ☐ Female | Height (ft-in.) | Weight (lbs.) |
| Occupation | | Applicant's email address (if any) | | Home Phone ( ) | Other Phone ( ) |
| Name of Employer | | Type of Business | | Have you used any tobacco products within the past 36 months? ☐ Yes ☐ No | |

1. Are you a US citizen? ☐ Yes ☐ No
2. If no to question 1, have you been issued a permanent residency VISA? ☐ Yes ☐ No
3. If yes to question 2, have you lived continuously in the US or Canada for the last 6 months? ☐ Yes ☐ No

## SPOUSE [& CHILDREN] INFORMATION – Complete if Applying for Dependent's Coverage

| Full Name | Occupation | Gender | Date of Birth mo | day | yr | Birth State or Country | Height ft /in | Weight lbs |
|---|---|---|---|---|---|---|---|---|
| (spouse) | | | | | | | | |
| [child] | | | | | | | | |
| [child] | | | | | | | | |
| [child] | | | | | | | | |

Has your spouse used any tobacco products within the past 36 months? ☐ Yes ☐ No

## SECTION 2 – PLAN SELECTION ☐ New Applicant ☐ Application for Change

Select Type of Policy:
[ ☐ Critical Illness With Cancer]
[ ☐ Critical Illness Without Cancer]

I hereby apply for the following coverage:
☐ Applicant Only
☐ Applicant & Spouse
[☐ Applicant & Children]
[☐ Applicant, Spouse & Children]

| | Face Amount Applying For (Increments of [$10,000]) | Number of Units ($5,000 per Unit) | | Rate | | Monthly Premium |
|---|---|---|---|---|---|---|
| Applicant | | | X | | = | $ |
| Spouse* | | | X | | = | $ |
| [Children** ☐ $5,000 ☐ 10,000] | | | X | | = | $ |

* Spouse's signature required if amount exceeds $25,000.
[** The maximum amount of Children's coverage is $10,000.]

TOTAL PREMIUM AMOUNT $

## SECTION 3 – BENEFICIARY ☐ Name Beneficiary ☐ Change of Beneficiary

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

| Name | Relationship | Date of Birth | Primary or Contingent | Indicate % Distribution |
|---|---|---|---|---|
| | | | ☐ Primary or ☐ Contingent | |
| | | | ☐ Primary or ☐ Contingent | |
| | | | Total must equal 100% = | |

| Applicant's Name (Last, First, M.I.) | Social Security Number |
|---|---|
| | |

## SECTION 4 – MEDICAL INFORMATION

NOTE: If Spouse [or Children] coverage IS NOT being requested answer questions only as applies to applicant.

1. Has any person to be insured ever been diagnosed with or advised to take a diagnostic test, been treated by a member of the medical profession, or taken medication for:

| | Yes | No |
|---|---|---|
| (a) Any form of internal cancer, carcinoma in-situ, malignant melanoma, or other precancerous findings? | ☐ | ☐ |
| (b) Any chronic or progressive disease or disorder of the heart, kidneys, liver, lungs, pancreas, or bone marrow? | ☐ | ☐ |
| (c) Quadriplegia, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease? | ☐ | ☐ |
| (d) Alcohol or substance abuse (in the last 5 years)? | ☐ | ☐ |
| (e) Heart Attack or heart disease, stroke or transient ischemic attack (TIA), or been advised to have coronary bypass surgery, stent insertion, or laser treatment to coronary arteries? | ☐ | ☐ |
| (f) Diabetes (except during a pregnancy), or any blood pressure reading recorded in the last three months exceeding 149/94? | ☐ | ☐ |
| (g) Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)? | ☐ | ☐ |

2. Has any person to be insured ever been diagnosed by a member of the medical profession with, or does anyone currently have:

| | Yes | No |
|---|---|---|
| (a) Any abnormal cancer screening tests currently being followed by your doctor? | ☐ | ☐ |
| (b) Any cysts, growths, lumps, or any mole or freckle that has bled, become painful, changed color, increased in size, required medical attention or evaluation for which you have not yet sought medical advice? | ☐ | ☐ |
| (c) Carotid artery stenosis, peripheral vascular disease, chronic atrial fibrillation, or chest pain not evaluated by a medical doctor and determined to be non-cardiac? | ☐ | ☐ |
| (d) Multiple sclerosis, memory loss, schizophrenia, systemic lupus erythematosus, pulmonary or cystic fibrosis? | ☐ | ☐ |

3. Has any person to be insured had any two or more natural parents, brothers, or sisters diagnosed with coronary artery disease, diabetes, or the same cancer (other than skin cancer) prior to age 55? Or, has any person to be insured had one or more natural parents, brothers, or sisters diagnosed with coronary artery disease or colorectal cancer prior to age 45? ☐ Yes ☐ No
4. Is any person to be insured currently taking any prescription medicine(s) or have they taken prescription medicine(s) in the last three (3) years? ☐ Yes ☐ No
5. Has any person to be insured had any abnormal tests (including blood test, urinalysis, X-ray, MRI, ultrasound, stress test, echocardiogram) not found to be normal or benign on further testing, or requiring follow-up by a physician? ☐ Yes ☐ No
6. Does any person to be insured have any consultation, surgery, or test scheduled or anticipated? ☐ Yes ☐ No
7. Has any person to be insured ever been diagnosed by a member of the medical profession with a benign tumor, disorder of blood or autoimmune disorder, digestive disorder, urinary system or reproduction organs disorder, heart or circulatory disorder, hypertension (list last two blood pressure readings and dates), mental or nervous disorder, neurological disorder, or respiratory disorder? ☐ Yes ☐ No
8. Has any person to be insured had any application for critical illness, disability, health, or life insurance modified, rated, or declined in the last 5 years? ☐ Yes ☐ No
9. Give details to any "Yes" answers, including name of person, prescription medicine(s), diagnosis, and dates of treatment: _____

   _____
10. Name, address, and phone number of the personal physician(s) of all applicants with date last seen, reason for visit, and results:

    _____

    _____

| Applicant's Name (Last, First, M.I.) | Social Security No. |
|---|---|
| | |

## SECTION 5 – AUTHORIZATION

1. Does any person applying for coverage currently have a Critical Illness or Cancer Policy with us or any other insurance company? ☐ Yes ☐ No
   If yes, give name of company, list type of policy and amount of coverage._____

2. REPLACEMENT: Is this insurance to replace or Change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company._____

3. OUTLINE: Have you received the Outline of Coverage (in those states required by law)? ☐ Yes ☐ No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" below; (c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (f) agree that this authorization shall be valid for two (2) years from the application date; (g) know that I or my authorized representative may revoke this authorization at any time; (h) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (i) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. I understand no person to be insured is also covered by any Title XIX program – Medicaid or any similar name (Not applicable to residents of AZ, MO, NC, OR, or SC). I understand failure to disclose a proposed insured person's true health condition may void this policy.

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application. I understand that my policy will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy. [I understand and accept that the coverage I am purchasing does not include dependent (child) coverage except for the initial 90 days from birth or adoption as stated in the policy and that no dependent (child) will be covered for an additional time period without the prior express written consent and approval of USAble Life.]

Insurance Fraud Warning – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

X _____ Signed at: _____
Applicant's Signature (City and State)

X _____ Date of Application: _____
Spouse's Signature (if required) (Month, Day, Year)

I have truly and accurately recorded the information supplied by the applicant.

X _____ _____
Agent's Signature Agent's License ID Number

_____
Agent's Printed Name

| Date Received Home Office |
|---|
| |

| | | | |
|---|---|---|---|
| ***SERFF Tracking #:*** | *LSVX-G128772798* | ***State Tracking #:*** | ***Company Tracking #:*** *AR001920100004* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *USAble Life* |
| ***TOI/Sub-TOI:*** | *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness* | | |
| ***Product Name:*** | *Critical Illness Applications, CIP2 & CIP2-R - Rev* | | |
| ***Project Name/Number:*** | *Critical Illness Applications, CIP, CIP2 & CIP2-R/AR001920100004* | | |

## Supporting Document Schedules

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Bypassed - Item: | Application | Approved-Closed | 11/16/2012 |
| Bypass Reason: | Not a policy filing | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Bypassed - Item: | Health - Actuarial Justification | Approved-Closed | 11/16/2012 |
| Bypass Reason: | Not a rate filing | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Bypassed - Item: | Outline of Coverage | Approved-Closed | 11/16/2012 |
| Bypass Reason: | Not a policy filing | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Flesch Certification | Approved-Closed | 11/16/2012 |
| Comments: | | | |
| Attachment(s): | | | |
| AR Readability Certification.PDF | | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Statement of Variability | Approved-Closed | 11/16/2012 |
| Comments: | | | |
| Attachment(s): | | | |
| CIP2-RAPP Statement of Variability.PDF | | | |

## STATE OF ARKANSAS

## READABILITY CERTIFICATION

**COMPANY NAME:** **USAble Life**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

| Form Number | Score |
|---|---|
| CIP2-APP (1-13) | 44.9 |
| CIP2-RAPP (1-13) | 44.9 |

Signed: 

Name: Sally A. Murphy

Title: Senior Counsel, Chief Compliance Officer and Assistant Secretary

Date: 11/15/2012

# STATEMENT OF VARIABILITY

***Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.***

## SPECIFIC VARIABLES
## CIP2-RAPP (1-13)

### Section 1 – Applicant Information

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

### Section 2 – Plan Selection

1. The type of policy is variable so that one type may be removed if that policy is not available. One type will always be included.
2. Under Face Amount Applying For, the increments can be $5,000 or $10,000.
3. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

### Section 5 – Authorization

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.